Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

KIDNEY CENTER PROGRAM

Billing Instructions

August 2000

Current Procedure Terminology CPT

About this publication

This publication supersedes all previous MAA Kidney Center Program Billing Instructions and Numbered Memorandum 00-36 MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
August 2000

Received too many billing instructions?
Too few?
Address incorrect?
Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Where do I call for information on becoming a DSHS provider?

Provider Enrollment Unit
(800) 562-6188
Select Option 1 -or-
(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136

Pharmacy Authorization?

(800) 848-2842

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Authorization - MAA approval for action taken for, or on behalf of an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Categorically Needy (CNP) - CNP programs are the federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for:

- CNP only;
- Cash benefits under the SSI (Supplemental Security Income);
- TANF (Temporary Assistance for Needy Families);
- General Assistance – X (special);
- General Assistance (children's).

CNP includes full scope coverage for pregnant women and children.

Client – An applicant for, or recipient of, DSHS medical care programs.

Client Liability – Either the amount:

- Of medical expenses incurred, which is the total of spenddown and Emergency Medical Expense Requirement; or

- Deducted from the hospital bill for which the client is liable. Enter this amount in *form locator 56: Est. Amount Due.* Subtract this amount from the total.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office(s) (CSO) - An office of the department which administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medical Assistance program.

Department - The state Department of Social and Health Services. (WAC 388-500-0005)

Emergency Medical Expense Requirement (EMER) – A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by Medical Assistance Administration (MAA) for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Emergency Medical Expense Requirement (EMER) – A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) cards – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons.

Medically Indigent (MIP) - The state-funded Medically Indigent (MIP) program provides very limited medical coverage for persons who:

- Have an emergency medical condition requiring hospital services; and
- Are not eligible for cash benefits or for any other medical program.

Medically Needy (MNP) – The Medicaid program for aged, blind, or disabled persons, pregnant women, children and refugees with income and/or resources above CNP limits. It provides, less medical coverage than CNP.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medicare - The federal government health insurance program for certain aged, disabled, or End Stage Renal Disease clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code assigned to each MAA client consisting of:

a) First and middle initials (a dash (-) must be used if the middle initial is not indicated).
b) Six-digit birth date, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha/Numeric character (tiebreaker).

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Field Services;
- Managed Care Contracts;
- Provider Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Qualified Medicare Beneficiary (QMB) - This is a Medicaid program for certain, low-income individuals who are also eligible for Medicare. The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicaid's allowed amount.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicaid's allowed amount.

- If **Medicare** does not cover the service, MAA will not reimburse the service.

Remittance and Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Spenddown – The process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department. (WAC 388-500-0005)

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual and Customary Fee – The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Kidney Center Program

About the Program

The Medical Assistance Administration (MAA) recognizes a freestanding kidney center as an outpatient facility. The Department of Social and Health Services (DSHS) Community Services Office (CSO) may determine that a client's spenddown/EMER applies to the dialysis services rendered. You and the client will receive a "Notice of Eligibility for Medical Care," noting EMER requirements (client participation).

MAA recognizes a kidney center as a conduit for funds disbursed to helpers. A copy of the signed uniform ***AGREEMENT FOR HOME DIALYSIS SERVICES*** (see Appendix A) is on file in the center for each Medical Assistance client for whom home dialysis services are reimbursed. Payments to helpers must be consistent with the payment terms of the agreement.

Provider Requirements

To receive reimbursement from MAA for providing care to Medical Assistance clients, kidney centers must:

- Have an MAA provider number;
- Be Medicare certified; and
- Submit a ***HOME DIALYSIS SERVICE FEE SCHEDULE*** if using home dialysis assistants/helpers. The home dialysis assistants/helpers in the center's service must adhere to this schedule.

Client Eligibility

Who is eligible?

Clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible for services under the Kidney Center program:

MAID Identifier	Medical Program
CNP - Children's Health	Categorically Needy Program - Children's Health
CNP - CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program - Emergency Medical Only
Emergency Hospital and Ambulance Only	Medically Indigent Program
GA-U - No Out of State Care	General Assistance - Unemployable
LCP-MNP	Limited Casualty Program-Medically Needy Program
QMB-Medicare Only	Qualified Medical Beneficiary*

Are clients enrolled in managed care eligible for kidney center services?

Clients with an identifier in the HMO column on their MAID card are enrolled in one of MAA's Healthy Options managed care plans. All kidney center services must be requested and authorized directly through the client's Primary Care Provider (PCP) and plan. Clients can contact their plan by calling the telephone number located on their MAID card. The client's plan covers hemodialysis or other appropriate procedures or treatment for renal failure to eligible members. The plan provides necessary equipment to the member for use in the course of treatment and recovers it when, in the opinion of the PCP, it is no longer necessary.

To prevent billing denials, please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and plan.

*** These clients are eligible for deductible and coinsurance only if Medicare has made payment.**

Coverage

What is covered?

The Medical Assistance Administration (MAA) covers the services listed in the fee schedule of these billing instructions.

What is not covered?

MAA does **NOT** cover the following services under the **Kidney Center Program**:

- Enteral Nutrition - MAA publishes separate billing instructions for these services. Only pharmacies or durable medical equipment (DME) providers may supply medical nutrition products. MAA does not require prior authorization for dialysis clients.
- Personal Care Items - Slippers, toothbrushes, combs, etc.
- Additional Personnel Charges - Payment includes kidney dialysis service charges (only home dialysis assistant/helper services are considered separate).
- Take Home Drugs - Take home drugs must be billed by a pharmacy subject to pharmacy pricing methodology outlined in MAA's Prescription Drug Program Billing Instructions. This includes immunosuppressive drugs after coverage by Medicare has ended.
- Telephone/Telegraph
- Transportation (Covered through the MAA Non-Ambulance Transportation Program only when prior authorized by the MAA-contracted transportation broker.)
- Television/Radio Rentals
- Freight Charges

☞ **Note:** Services that are **NOT** covered by Medicare must be billed on a separate UB-92 claim form. (Do not include noncovered Medicare services on a claim with services that **ARE** covered by Medicare).

Fee Schedule

HCFA Common Procedural Coding System (HCPCS) Codes

HCPCS Codes for Blood Processing Used in Outpatient Blood Transfusions

☞ **Note:** MAA does not reimburse providers for blood and blood derivatives. Reimbursement is limited to blood bank service charges for processing the blood and blood products (refer to WAC 388-550-6500). The HCPCS blood codes listed below must be used to represent the following costs: 1) blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves; or 2) costs incurred by a center to administer its in-house blood procurement program. However, these costs must not include any staff time used to administer blood.

HCPCS Procedure Code	Blood Processing for Transfusion	Maximum Allowable Fee
P9010	Blood (whole), for transfusion, per unit	$55.11
P9011	Blood (split unit), specify amount	By Report
P9012	Cryoprecipitate, each unit	26.20
P9016	Red blood cells, leukocytes reduced, each unit	45.53
P9017	Fresh frozen plasma (single donor), each unit	47.82
P9019	Platelets, each unit	By Report
P9020	Platelet rich plasma, each unit	By Report
P9021	Red blood cells, each unit	66.64
P9022	Red blood cells, washed, each unit	20.50
P9023	Plasma, pooled multiple donor, solvent/detergent treated, frozen, each unit	By Report
P9031	Platelets, leukocytes reduced, each unit	By Report
P9032	Platelets, irradiated, each unit	By Report
P9033	Platelets, leukocytes reduced, irradiated, each unit	By Report
P9034	Platelets, pheresis, each unit	By Report
P9035	Platelets, pheresis, leukocytes reduced, each unit	By Report
P9036	Platelets, pheresis, irradiated, each unit	By Report
P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit	By Report

HCPCS Procedure Code	Blood Processing for Transfusion	Maximum Allowable Fee
P9038	Red blood cells, irradiated, each unit	By Report
P9039	Red blood cells, deglycerolized, each unit	By Report
P9040	Red blood cells, leukocytes reduced, irradiated, each unit	By Report
P9041	Infusion, albumin (human), 5%, 50 ml	By Report
P9043	Infusion, plasma protein fraction (human), 5%, 50 ml	By Report
P9044	Plasma, cryoprecipitate reduced, each unit	By Report
P9045	Infusion, albumin (human), 5%, 250 ml	By Report
P9046	Infusion, albumin (human), 25%, 20ml	By Report
P9047	Infusion, albumin (human). 25%, 50ml	By Report
P9048	Infusion, plasma protein fraction (human), 5%, 250ml	By Report
P9050	Granulocytes, phereis, each unit	By Report

Drugs Codes Allowed by Medicare using Revenue Code 636

Procedure Code	Name of Drug	Admin. Dosage
90657*	Influenza Virus Vaccine, 6-35 months dosage, for intramuscular or jet injection use	
90658*	Influenza Virus Vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use	
90659*	Influenza Virus Vaccine, whole virus, for intramuscular or jet injection use	
90732*	Pneumococcal Polysaccharide Vaccine, 23-Valent, Adult Dosage, For Subcutaneous or Intramuscular Use	
90747*	Immunization, Active: Hepatitis B Vaccine	40 mcg
J0280	Injection, aminophyllin	250 mg
J0285	Amphotericin	50 mg
J0290	Ampicillin Sodium	500mg
J0295	Ampicillin Sodim/Sulbactam sodium	1.5 g
J0360	Injection, hydralazine HCl	20 mg
J0530	Penicillin G procaine	600,000u

* **These are Current Procedural Terminology (CPT™) codes.**

Procedure Code	Name of Drug	Admin. Dosage
J0610	Calcium Glucontate	10ml
J0630	Calcitnonin Salmon	400u
J0635	Calcitriol	1mcg
J0640	Leucovorin Calcium	50 mg
J0690	Cefazolin Sodium	500mg
J0694	Cefoxitin Sodium	1gm
J0696	Ceftriaxone Sodium	250mg
J0697	Cefuroxime Sodium	750mg
J0702	Betamethasone Acetane and Betamehasone Sodium Phosphate	3 mg
J0704	Betamethasone Sodium Phosphate	4 mg
J0710	Cephapirin Sodium	1gm
J0713	Ceftazidime	500 mg
J0745	Codeine Phosphate	30mg
J0780	Prochlorperazine	10mg
J0895	Deferoxamine Mesylate	500mg
J0970	Estradiol Valerate	40mg
J1060	Testosterone Cypionate and Estradiol Cypionate	1 ml
J1070	Testosterone Cypionate	100 mg
J1080	Testosterone Cypionate, 1 cc	200 mg
J1095	Dexamethasone Acetate	8 mg
J1160	Digoxin	.5 mg
J1165	Phenytoin Sodium	50mg
J1170	Hydromorphone	4mg
J1200	Diphenhydramine HCl	50 mg
J1240	Dimenhydrinate	50mg
J1580	Gentamicin Sulfate	80mg
J1630	Haloperidol	5 mg
J1631	Haloperidol Decanoate	50 mg
J1645	Dalteparin Sodium	2500 IU
J1720	Hydrocortisone Sodium Succinate	100mg
J1750	Iron Dextran	50 mg
J1755	Iron Sucrose	20 mg
J1790	Droperidol	5mg
J1800	Propranolol HCl	1 mg
J1840	Kanamycin Sulfate	500mg
J1885	Ketorolac Tromethamine	15 mg
J1890	Cephalothin Sodium	1gm

Procedure Code	Name of Drug	Admin. Dosage
J1940	Furosemide	20mg
J1955	Levocarnitine	1 gm
J1990	Chlordiazepoxide HCl	100 mg
J2060	Lorazepam	2 mg
J2150	Mannitol 25%	50 ml
J2175	Meperidine HCl	100mg
J2270	Morphine Sulfate	10mg
J2275	Morphine Sulfate (sterile solution)	10 mg
J2320	Nandrolone Decanoate	50mg
J2321	Nandrolone Decanoate	100mg
J2322	Nandrolone Decanoate	200mg
J2500	Paricalcitol	5 mcg
J2510	Penicillin G Procaine Aqueous	600,000u
J2540	Penicillin G Potassium	600,000u
J2550	Promethazine HCl	50mg
J2560	Phenobarbital Sodium	120mg
J2690	Procainamide HCl	1gm
J2700	Oxacillin Sodium	250mg
J2720	Protamine Sulfate	10mg
J2765	Metoclopramide HCl	10mg
J2800	Methocarbamol	10 ml
J2915	Sodium Ferric Gluconate Complex in Sucrose Injection	62.5mg
J2920	Methylprednisolone Sodium Succinate	40 mg
J2930	Methylprednisolone Sodium Succinate	125 mg
J2995	Streptokinase	250,000 IU
J2997	Alteplase Recombinant	1 mg
J3000	Streptomycin	1gm
J3010	Fentanyl Citrate	0.1mg
J3070	Pentazocine HCl	30mg
J3120	Testosterone Enanthate	100mg
J3130	Testosterone Enanthate	200mg
J3230	Chlorpromazine HCl	50mg
J3250	Trimethobenzamide HCl	200mg
J3260	Tobramycin Sulfate	80mg
J3280	Thiethylperazine Maleate	10mg
J3301	Triamcinolone Acetonide	10 mg
J3360	Diazepam	5mg

Procedure Code	Name of Drug	Admin. Dosage
J3364	Urokinase	5,000 IU vial
J3365	IV Urokinase	250,000 IU vial
J3370	Vancomycin HCl	500 mg
J3410	Hydorxyzine HCl	25 mg
J3420	Vitamin B-12 Cyanocobalamin	1,000 mcg
J3430	Phytonadione (Vitamin K)	1mg
J3490	Unclassified Drugs **(see note)**	
P9006	Supplies used to administer blood	Acquisition Cost
P9008	IV pump used to administer IV drugs	Acquisition Cost

Note: The National Drug Code (NDC) number must be included in the comments section of the claim form when billing unlisted drug HCPCS code J3490.

Revenue Codes

Revenue Code	Description	9/1/02 Maximum Allowable Fee
	Pharmacy	
250*	Immunosuppressive drugs	By Report
260	Administration of drugs by IV/intra muscular (non-renal related and/or not covered by Medicare).	By Report
	Medical/Surgical Supplies and Devices	
270*	Medical/surgical supplies	$.50/per supply package
	Laboratory	
303	Laboratory, renal patient (home)	By Report
304	Laboratory, non-routine dialysis	By Report

* **For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services will be covered by Medicare at 80%.**

Revenue Code	Description	9/1/02 Maximum Allowable Fee
	Epoetin (EPO) Injections **Note:** When billing with revenue codes 634 and 635, each one unit reported on the claim form represents 1,000 units of EPO given.	
634*	Erythropoietin (EPO) less than 10,000 units	By Report
635*	Erythropoietin (EPO) 10,000 or more units	By Report
	Drugs Requiring Specific Identification	
636*	Drugs requiring detailed coding **(see note)**	See pages 9 - 10c
	EKG/ECG (Electrocardiogram) – Technical Portion Only	
730*	General classification	By Report
	Hemodialysis - Outpatient or Home	
821*	Hemodialysis/composite rate	$197.45/per session
825	Support Services (Home Helper)	By Report
	Peritoneal Dialysis - Outpatient or Home	
831*	Peritoneal dialysis **(Not in combination with 841, 851, and 880)**	$197.45/per session
845	Support Services (Home Helper)	By Report
	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	
841*	CAPD/Composite Rate **(Not in combination with 831, 851, and 880)**	$84.62/per session
845	Support Services (Home Helper)	By Report

☞ **Note:** Revenue code 636 relates to HCPCS codes, so HCPCS codes must be used in Form Locator 44. Providers must use the description of the procedure code and include the correct number of units on the claim form in order to be reimbursed the appropriate amount. For a listing of HCPCS codes to be used with revenue code 636, refer to pages 9-10c of this fee schedule.

*** For clients who have dual coverage (Medicare/Medicaid) the asterisked (*) drugs, supplies, and services will be covered by Medicare at 80%.**

Revenue Code	Description	9/1/02 Maximum Allowable Fee
	Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home	
851	CCPD/Composite Rate **(Not in combination with 831, 841, and 880)**	$84.62/per session
855	Support Services (Home Helper)	By Report
	Miscellaneous Dialysis	
880	General Classification **(Not in combination with 831, 841, and 851)**	$197.45/per session
881	Ultrafiltration	By Report

Reimbursement

How does MAA reimburse for kidney center services?

MAA reimburses free-standing kidney centers for providing kidney center services to MAA clients using one of the following payment methods:

- **Composite rate payments** - A payment method in which all standard equipment, supplies, and services are calculated into a blended rate, known as a "composite rate." All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.

  - ✓ A single dialysis session and related services are reimbursed through a single composite rate payment (see "*What does the composite rate include?*" for a detailed description on what is required and paid for in a composite rate payment).

  - ✓ The composite rate is:

    - ➢ $197.45 per dialysis session for revenue codes 821, 831, and 880; and
    - ➢ $84.62 per dialysis session for revenue codes 841 and 851.

- **Fee-for-service payments** – The general payment method MAA uses to reimburse for covered medical services when these services are not covered under the composite rate. This methodology uses a maximum allowable fee schedule to reimburse providers (see "*What items and services are payable through Fee-For-Service?*" for more detail on fee-for-service payments).

- **Limitations on payment** – MAA evaluates requests for covered services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standards of WAC 388-501-0165.

What does the composite rate include?

- All standard equipment, supplies, and services for in-facility and home dialysis are included in the composite rate.

- The following items and services are included in a composite rate payment:

  - ✓ Bicarbonate dialysis;
  - ✓ Cardiac monitoring;
  - ✓ Crash cart usage for cardiac arrest;
  - ✓ Suture removal;
  - ✓ Dressing changes;
  - ✓ Administration of drugs related to treatment;
  - ✓ Medically necessary dialysis equipment;
  - ✓ All dialysis services furnished by the facility's staff;
  - ✓ Routine ESRD related laboratory tests;
  - ✓ Home dialysis support services including the delivery, installation, and maintenance of equipment;
  - ✓ Purchase and delivery of all necessary dialysis supplies;
  - ✓ Staff time used to administer blood;
  - ✓ Declotting of shunts and any supplies used to declot shunts;
  - ✓ Oxygen and the administration of oxygen;
  - ✓ Staff time used to collect specimens for all laboratory tests;
  - ✓ Staff time used to administer nonroutine parenteral items; and
  - ✓ Parenteral drugs.

- MAA issues a composite rate payment only when all of the above items and services are furnished or available at each dialysis session.

- MAA allows the following number of dialysis sessions:

  - ✓ For revenue codes 821, 831, and 880, a maximum of three (3) per week and no more than 14 per month.
  - ✓ For revenue codes 841 and 851, a maximum of seven (7) per week and no more than 31 per month.

  Providers may request a limitation extension (LE) if more than 14 sessions per month are medically necessary. Fax LE requests, including reason(s) for medical necessity, to (360) 586-1471.

- If the facility fails to furnish or have available <u>any</u> of the above items, MAA will not pay for any part of the items and services that were furnished.

What items and services are payable through Fee-For-Service?

The following items and services are not included in the composite rate and may be billed on a fee-for-service basis subject to the restrictions or limitations in these billing instructions and other applicable published WAC:

- Drugs related to treatment such as epoetin or iron replacement products.
  - ✓ The drug must be prescribed by a physician; and
  - ✓ Must meet the rebate requirements described in WAC 388-530-1125.
- Supplies used to administer drugs and blood.
- Blood processing fees.
- Laboratory tests for renal patient or nonroutine dialysis.

> ☞ **Note:** Staff time for the administration of blood is included in the composite rate.

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  ✓ The date the provider furnishes the service to the eligible client;
  ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  ✓ The date a court orders MAA to cover the services; or
  ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

Note:	If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  ✓ DSHS certification of a client for a retroactive[2] period; or
  ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

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[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

> ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. Please refer to the client's MAID card for the PCCM.

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in form locator 82 on the UB-92 (HCFA-1450) claim form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in form locator 82 when you bill MAA, the claim will be denied.

  Newborns of Healthy Options clients that are connected with a PCCM are fee-for-service until the client has chosen a PCCM. All services should be billed to MAA.

> ☞ **Note:** If you treat a Healthy Options client that has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, you may not receive payment. You will need to contact the PCP to get a referral.

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Effective April 1, 1999, payments for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service (whether normally DRG or RCC reimbursed) had the service been reimbursed under the ratio of costs-to-charges (RCC) payment method.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicaid's allowed amount.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicaid's allowed amount.
- If only Medicaid **and not Medicare** cover the service and the service is covered under the CNP or MNP program, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicaid's allowed amount.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicaid's allowed amount.
- If **Medicare does not** cover the service, MAA will not reimburse the service.

What records must be kept? **[Refer to WAC 388-502-0020]**

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome;
  - ✓ Specific claims and payments received for services; and
  - ✓ Home Dialysis service fee schedule, plus any subsequent updates.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for at least six years from the date of service</u> or more if required by federal or state law or regulation.**

How to Complete the UB-92 Claim Form

Only form locators that pertain to billing MAA are addressed below.

When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).

When billing electronically, indicate claim type "M" for Outpatient.

FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION:

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No.** - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** – Enter 722 or 723 (indicates free-standing ESRO facility).

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Assistance IDentification (MAID) card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birth date.

15. **Patient Sex** – Male or female

42. **Revenue Code** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Revenue or Procedure Description** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **HCPCS/Rates** - Enter the accommodation rate for inpatient bills or HCFA Common Procedural Coding System (HCPCS) code.

46. **Units of Service** - Enter the number of dialysis sessions and/or EPO units for which you are billing.

47. **Total Charges** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **Noncovered** – Enter any noncovered charges pertaining to detail revenue or procedure codes here. (MAA will *categorically deny* these services.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C** - Enter if health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51. **Provider Number** - Enter the kidney center provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

54. **Prior Payments: A/B/C** - Enter the amount due or received from other insurance.

55. **Estimated Amount Due: A/B/C** - The amount estimated by the kidney center to be due from the indicated payer (estimated responsibility less prior payments).

58. **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

59. **Patient's Relationship to Insured A/B/C** – Enter one of the following two-digit codes indicating the relationship of the patient to the identified insured:

Code	Description
01 =	Patient is insured
02 =	Spouse
03 =	Natural child/insured has financial responsibility
04 =	Natural child/insured does not have financial responsibility
05 =	Step child
06 =	Foster child
07 =	Ward of court/patient ward of insured
08 =	Employee/patient employed by insured
09 =	Unknown
10 =	Handicapped dependent
11 =	Organ donor
12 =	Cadaver donor
13 =	Grandchild
14 =	Niece/nephew

Code	Description
15 =	Injured plaintiff/patient claiming insurance as result of injury covered by insured
16 =	Sponsored dependent
17 =	Minor dependent of minor dependent
18 =	Parent
19 =	Grandparent

60. **Cert-SSN-HIC-ID NO.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card. This information is obtained from the client's current monthly MAID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birth date, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tiebreaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

63. **Treatment Authorization Code -** A number which designates the treatment covered by this bill has been authorized by the payer.

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

82. **Attending Physician I.D.** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

83. **Other Physician I.D. -** The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.

84. **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form.

Sample: Level A Services UB-92 Claim Form

How to Complete the UB-92 Medicare Part A/Medicaid Crossover Claim Form

[Use these instructions when submitting claims for dual-eligible (Medicare/Medicaid) clients.]

You must submit the Medicare/Medicaid billing form UB-92 along with a copy of your Explanation of Medicare Benefits (EOMB)to:

Division of Program Support
PO Box 9246
Olympia WA 98507-9246

The numbered boxes on the claim form are referred to as ***form locators***. *Only form locators that pertain to MAA are addressed here.*

Complete the UB-92 claim form in the usual manner required by MAA. However, there are form locators that need specific information indicated in order to process your claim. See the following instructions and claim form samples.

FORM LOCATOR, NAME AND INSTRUCTION FOR COMPLETION

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

3. **Patient Control No**. - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** – Enter 721 or 723 (indicates free-standing ESRO facility).

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's MAID card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birth date.

39-41. <u>Value Codes and Amounts</u>

39A: **<u>Deductible</u>**: Enter the code *A1*, and the deductible as reported on your EOMB.

40A: **<u>Coinsurance</u>**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

41A: **<u>Medicare Payment</u>**: Enter the payment by Medicare as reported on your EOMB.

42. **<u>Revenue Code</u>** - Enter the appropriate revenue code(s) from the listing in this manual. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **<u>Procedure Description</u>** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

44. **<u>HCPCS/Rates</u>** - Enter the accommodation rate for inpatient bills, or the appropriate HCPC code.

46. **<u>Units of Service</u>** - Enter the quantity of services listed by revenue or procedure code(s).

47. **<u>Total Charges</u>** - Enter charges pertaining to the related revenue code(s) or procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

48. **<u>Noncovered</u>** – Enter any noncovered charges pertaining to detail revenue or procedure codes here. (MAA will *categorically deny* these services.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **<u>Payer Identification: A/B/C</u>** - Enter if health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

51. **<u>Provider Number</u>** - Enter the provider number issued to you by the payer.

51A: Enter the seven-digit Medicaid provider number that appears on your Remittance and Status Report.

51B: Enter your Medicare provider number.

54. **<u>Prior Payments: A/B/C</u>** - Enter the amount due or received from other insurance.

55. **<u>Estimated Amount Due: A/B/C</u>** - The amount estimated by the kidney center to be due from the indicated payer (estimated responsibility less prior payments).

58. **<u>Insured's Name: A/B/C</u>** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

59. **Patient's Relationship to Insured A/B/C** – Enter one of the following two-digit codes indicating the relationship of the patient to the identified insured:

Code	Description
01 =	Patient is insured
02 =	Spouse
03 =	Natural child/insured has financial responsibility
04 =	Natural child/insured does not have financial responsibility
05 =	Step child
06 =	Foster child
07 =	Ward of court/patient ward of insured
08 =	Employee/patient employed by insured
09 =	Unknown
10 =	Handicapped dependent
11 =	Organ donor
12 =	Cadaver donor
13 =	Grandchild
14 =	Niece/nephew
15 =	Injured plaintiff/patient claiming insurance as result of injury covered by insured
16 =	Sponsored dependent
17 =	Minor dependent of minor dependent
18 =	Parent
19 =	Grandparent

60. **Cert-SSN-HIC-ID No.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card. This information is obtained from the client's current monthly MAID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birth date, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tie breaker).

61. **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

62. **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

65. **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

67. **<u>Principal Diagnosis Code</u>** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

68-75. **<u>Other Diagnosis Codes</u>** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

82. **<u>Attending Physician I.D.</u>** - Enter the seven-digit provider identification number of the attending physician. Do not complete this box with a clinic billing number. For attending physicians not enrolled in the Medical Assistance program, enter the name of the attending physician in this form locator.

84. **<u>Remarks</u>** - Enter any information applicable to this stay that is not already indicated on the claim form.

Sample: Medicare Part A/Medicaid Crossover UB-92 Claim Form

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AGREEMENT FOR HOME DIALYSIS SERVICES

This agreement between _______________________________("the patient") and _____________________________________ ("the Home Dialysis Assistant/Helper") sets forth our respective understanding and responsibilities for the dialysis to be provided in the patient's home.

This agreement relates to the home dialysis treatment program funded by the Department of Social and Health Services, hereafter known as DSHS. Local kidney centers have been providing training and other support services and serving as a conduit for DSHS funding. We understand that the Home Dialysis Assistant/Helper is not employed by DSHS or by the _________________________Kidney Center hereafter known as the Kidney Center, and neither DSHS nor the Kidney Center is responsible or liable for the activities of the patient or the Home Dialysis Assistant/Helper.

We understand that the Home Dialysis Assistant/Helper is an independent contractor, selected solely by and responsible to the patient. Either the patient or the Home Dialysis Assistant/Helper may terminate this relationship at any time.

The fee schedule set forth in Appendix A, attached to this agreement, indicates the maximum allowance and constitutes payment in full for the services to be rendered by the Home Dialysis Assistant/Helper to the patient under this agreement. DSHS policy provides that no additional charge to the patient is allowed. Duties to be performed by the Assistant are limited to dialysis only; other activities, such as housekeeping, cooking, shopping, child care or cleaning, are non-reimbursable.

The Home Dialysis Assistant/Helper agrees to complete the demodialysis log at the conclusion of each home dialysis. At the end of each month, the Assistant shall submit the log to the patient for review and signature. A copy of the monthly hemodialysis log with complete instructions is attached to this agreement as Appendix B. The patient agrees to cooperate in completely filing in the hemodialysis log. Both the Assistant and patient shall sign the log to verify its accuracy. The Dialysis Assistant shall submit the log to the Kidney Center in no case less often than once a month for processing and subsequent payment. The reimbursement check for the Home Dialysis Assistant/Helper's services will be made out jointly to the Patient and the Assistant. The patient agrees to countersign the reimbursement check so the Assistant can cash the check.

As an independent contractor, the Home Dialysis Assistant/Helper, understands and assumes all responsibility for maintaining adequate financial records and payments of all appropriate taxes, including federal income taxes and FICA (Social Security taxes). The Assistant will not receive earnings reports from any source.

The Home Dialysis Assistant/Helper understands that he/she is not entitled to vacation pay, sick leave, medical or dental insurance, retirement benefits, worker's compensation or any compensation benefits other than those specified in this agreement.

If the Home Dialysis Assistant/Helper is not available as regularly scheduled, the Assistant agrees to immediately contact the patient and the Kidney Center so that other arrangements for dialysis treatment can be made. The Home Dialysis Assistant/Helper also agrees to review and schedule desired vacation times with the patient and the Kidney Center before confirming travel arrangements. If given sufficient advance notice, and if other Assistants have not already requested vacation at the same time, the Kidney Center can assist in scheduling the patient for alternative dialysis during the Assistant's vacation.

If for any reason the patient will not be dialyzed on a scheduled day, the Home Dialysis Assistant/Helper agrees to notify the patient's nephrologist in advance. If the nephrologist does not approve the altered scheduled, the Assistant shall contact the Kidney Center to attempt to arrange for dialysis on the normal schedule.

The patient agrees to cooperate during any training or re-training that may be necessary to prepare a Home Dialysis Assistant/Helper to assume the duties set forth in this agreement and in Appendix C. The Assistant agrees to participate in any such required training or re-training and agrees to accept the authorized schedule of compensation of such training as set forth in Appendices A and C.

Signed this ________________ day of ______________________, 19____, at ____________________________Washington.

____
Patient

____
Home Dialysis Assistant/Helper

____ ______________________________
Witness *Date*

____ ______________________________
Witness *Date*

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